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ABSTRACT

Health behavior may be influenced by age, beliefs, and symptomatology. To examine age-related health beliefs and behaviors with respect to six diseases (the common cold, colon-rectal cancer, lung cancer, heart attack, high blood pressure, and senility), 396 adults (196 males, 200 females) divided into three age groups completed a questionnaire assessing health practices, perceived effectiveness of preventive behaviors, illness attributes, coping, and symptoms as disease warnings. Age group composition was as follows: (1) 173 adults, aged 20-39; (2) 111 adults, aged 40-59, and (3) 112 adults, aged 60 or older, and responses were analysed according to group. Results showed that all subjects reported engaging in health promotion behaviors (e.g., eating a balanced diet, getting enough sleep) at least occasionally. All behaviors showed increased frequency of performance with age except aerobic exercise and physical exertion which decreased with age. Although most actions were not perceived as effective, some actions were accepted as effective for specific diseases (e.g., restricting salt to prevent high blood pressure). Older adults were more likely to believe that illness could be prevented by avoiding strenuous exercise and avoiding harmful health behaviors, while younger adults believed that strenuous exercise prevented disease. Finally, older persons saw themselves as more vulnerable to the six illnesses, and they believed the illnesses would be more severe if they contracted them. (Numerous tables are appended to highlight the results). (BL)

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Age Related Changes in Preventive Health Behavior

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For several years now we have been investigating peoples' health beliefs and health behavior. Our present goal is to see if these beliefs and behaviors change with age and whether we can locate the causes of these changes and their consequences for using health services.

In this study we examined health beliefs and behaviors with respect to six different diseases: 1. the common cold; 2. colon-rectal cancer; 3. lung cancer; 4. heart attack; 5. high blood pressure; and 6. senility. We chose to study the latter five diseases because each of them is seen as more likely with advancing age (Keller, et al, 1983). Two of them, heart attack and high blood pressure, are very common and likely to be seen as serious and potentially preventable. The two cancers, on the other hand, are also seen as very serious but are unlikely to be seen as preventable. It would be of interest, therefore, to see if health behaviors and beliefs respecting the prevention of these last two pairs of illness change in different ways as people get older.

Senility was included in the set as it is the illness that is most clearly seen as age related and because it may carry significant stigma. Comparing older and younger persons' beliefs and behaviors respecting this illness would, therefore, be of special interest.

Finally, the common cold was included as a 'control' illness. It has no specific relationship to age, is not likely to be seen as either preventable or non-preventable, and provides a valuable comparison to see if age differences in health beliefs and behaviors with respect to serious diseases carry over to a relatively innocuous

illness.

We questioned our subjects as to how frequently they engaged in health behaviors such as: 1. taking vitamins; 2. doing strenuous exercise; 3. eating bran; 4. avoiding emotional stress; 5. getting enough sleep. We also asked the respondents if they believed the specific behavior could prevent one of the 6 diseases. We could then compare the frequency with which subjects at different ages reported doing these behaviors and whether they differed in how effective they perceived them to be for each disease.

We examined beliefs about the specific disease with respect to the following issues: 1. the likelihood of getting the disease; 2. prodroma or onset time; 3. preventability; 4. perceived severity; 5. belief in ability to engage in preventive behavior; and 6. the time frame for effectiveness of preventive actions. Answers to these questions tell us how our respondents perceive or REPRESENT the disease and their beliefs in their ability to Control or cope with it.

We asked the respondents about their emotional reactions to the disease, whether they would be angry, ashamed or frightened if they got it, and how much it would interfere with their daily lives. These questions assessed the EMOTIONAL reactions to the illness.

Finally, we asked the respondent to check the signs and symptoms that are viewed as warnings of the illness. These questions provide us with the cues used to identify the presence of disease risk.

In summary, we are addressing four aspects of health behaviors and beliefs concerning the prevention of various illnesses. The first provides a more comprehensive cross-sectional profile of individual

preventive health behaviors across the adult life-span. Age patterns in reported frequencies as well as the degree to which these behaviors relate to each other will be reviewed. Secondly, beliefs about the efficacy of each behavior for specific disease prevention and the age patterns for these beliefs are examined. Third, we will see whether age variations in the frequency and perceived effectiveness of these health behaviors reflect changes in how respondents perceive or represent and believe they can cope with the specific illness. Finally, we will examine the relationship between cues or symptoms warning of these illnesses and preventive behaviors and beliefs.

Method

Subjects and Setting

Volunteers were recruited from persons attending three public health fairs conducted on three consecutive weekends in a midwestern city. A total of 396 persons, 196 males (X age 45.2 years SD = 17.0) and 200 females (X age 46.5 years, SD = 18.5) divided into the following age groups: 173 aged 20-39, mean age 29.5; 111 aged 40-59, mean age 47.1; and 112 aged 60 or older, mean age 69.7, were used in the analyses. The only requirement for inclusion was that the person had to be able to read the questionnaire and be 20 years of age or older.

Design

Because we could not ask for more than 5 or 10 minutes of any respondent's time, we prepared separate questionnaires for each of the 6 diseases, and distributed them randomly to our volunteer

respondents. The size of the age group for each questionnaire is presented in the data tables.

The questionnaire was designed to assess each of four areas:

A. The individual's reported health practices: These questions covered 21 health practices such as: 1. avoiding salt and heavily salted foods, 2. taking vitamins, 3. avoiding people with (disease under study), 4. avoiding emotional stress, 5. getting enough sleep, 6. have regular medical check ups, etc. All items used 5 point Likert scales with 1 = Never (do the behavior) and 5 = Always (do the behavior).

B. The perceived effectiveness of each of the preventive behaviors: These ratings were made for one disease by each participant.

C. The subjects' representation or perception of the key attributes of the illness problem: Included were items about the likelihood of contracting the disease/illness, prevention, severity, intrusion on normal daily activities and whether these illnesses would effect their longevity. The fear, shame and anger associated with these illnesses was also assessed.

D. Beliefs in ability to control or cope: Individuals were asked to predict whether they could avoid disease by preventive health behaviors, whether they were capable of actually carrying out such behaviors, whether they had experimented with preventive actions, and whether the disease was cureable.

E. Symptoms as disease warnings: From a list of 16 symptoms, subjects were asked to identify those that they would see as warning

signs of disease in themselves.

Procedure

Each potential subject was approached individually and asked to participate in a health survey. While no frequencies were kept, few refused to cooperate. Each person was told that there were no right or wrong answers, we were only interested in opinions, behaviors, and beliefs. The end of the questionnaire contained a statement that thanked respondents for their cooperation and noted that there was 'as yet little or no evidence to support most of the actions' that were queried in the study and we were making no recommendations, either positive or negative about them.

Results

We categorized the behaviors into health promotion items (e.g. eat balanced diet; get enough sleep) and cognitive affective items (e.g. avoid emotional stress; stay mentally alert). We then computed planned comparisons between the three age-groups to detect age-related linear trends. Table 1 contains the mean scores for those health promotion behaviors which showed significant age-related differences at the .01 level or better (1 = never do this, 5 = always).

All subjects reported engaging in these behaviors at least occasionally and all of the health promotion behaviors in Table 1 showed increased frequency of performance with age except for aerobic exercising and physical exertion which decreased with age. There also

were significant sex differences for eating bran, getting medical check-ups and avoiding salt. More females engaged in these practices than males.

For the cognitive affective health behaviors, (Table 2) older persons reported that they attempted to avoid anger, anxiety, and depression; avoid emotional stress; take things as they come along and attempt to stay mentally alert and active. The increase in reported frequency for older people for all four of these cognitive affective health behaviors was significant at less than the .01 level.

We computed Pearson correlations between the behavior items to see whether there is any consistency between them and to identify how they cluster together. Most of the intercorrelations were significant ($p<.01$) though of small size, e.g. between .12 and .19. The two most highly correlated items ($r = .55$) were the frequency reported for finding out what others do to prevent illness and getting medical information while the largest negative correlations ($r = -.45$) was between avoiding physical exertion and strenuous or aerobic exercise. These data are similar to those found in other studies (Harris and Guten, 1979; Langlie, 1977, 1979; Mechanic, 1979).

Perceived Effectiveness of Health Behaviors

We examined the beliefs about the effectiveness of the 13 preventive health actions which showed age differences. There were large differences in the perceived effectiveness of these health promotion behaviors for the 6 illnesses (see Table 3). Any behaviors rated 3.5 or greater on 1-5 Likert-type scales are highlighted by an

asterisk *. The pattern of the disease differences is clearly related to what we have called 'common-sense' or cultural notions about illness. For example, avoiding salt is seen as effective in preventing high blood pressure and heart attacks. Avoiding harmful health habits, such as smoking and excessive drinking were seen as effective for the prevention of all 6 illnesses, i.e., from senility through cancers and heart disease to colds.

All four cognitive-affective strategies (Table 4) were seen as effective in preventing cardio-vascular dysfunction (heart attack, hypertension) but were not seen as effective in preventing the other diseases. Finally, staying mentally alert and active was seen as effective prevention of senility.

While there were age differences in the reported frequency of performance of all 13 of these preventive health behaviors, there were statistically significant age differences for the perceived effectiveness of only 3 of the 13 items. The older respondents were more likely to believe that illness could be prevented by 1.) avoiding strenuous aerobic exercise; 2.) avoiding harmful health behaviors such as smoking and excessive drinking. Younger respondents believed that strenuous exercise would be effective in preventing disease.

There are no age related differences in beliefs about the effectiveness of cognitive affective health behaviors.

Health Beliefs: Representations: Emotion and Coping

In previous studies, we have shown that the representation of illness or the threat of illness influences the individual's health behaviors. We were interested in finding out if there were

differences in the representations of the 6 diseases and whether the 3 age groups differed in the questions measuring the representation. First we performed an analysis of variance to see if the type of illness and the respondent's age affected responses to the representation items.

Tables 5 and 6 contain the means for responses to the representation items by type of illness. Significant differences were found for all 15 items grouped into categories that fit our illness representation model.

Table 7 shows the age differences that appeared for 6 of the representational items. The elderly see themselves as more vulnerable to disease, even when comparing themselves to members of their own age cohort and see these diseases as more serious for themselves. They also state that they would show less anger and fear if they were to be afflicted with these diseases than their younger counterparts . . . a finding consistent with our previous studies. The elderly also reported that they have experimented more often with ways to prevent disease.

Symptoms

We next looked to see which of a set of 16 symptoms the respondents said they could use as warning signs for the six diseases in our study. Two symptoms were frequently seen to be signs of all six diseases: they were tiredness (62%) and lack of energy (58%). Weakness was mentioned about 35% of the time for most illnesses. The remaining symptoms form interesting disease specific clusters; for the 2 types of cancer, the warning signs and symptoms were pain, loss

of weight, and loss of appetite (Table 8). Constipation and diarrhea were only linked to colonic cancer. The most characteristic symptom of heart attack was pain. For colds, the warning signs were stuffy nose, (specific to cold), lack of energy, headache, aches and cough. Headache was also associated with hypertension as were tiredness and lack of energy (the classic lay associated symptoms of this disease). Forgetfulness was singularly related to senility, though 66% also associate lack of energy with this disease.

These findings on the common sense associations of illnesses to symptoms fit well with our previous research findings. We were more interested here, however, in finding out whether the association of symptoms with specific illnesses change with the individual's age. Our three age groups differed in how they used three of the 16 symptoms to identify diseases (Table 9). Our older respondents were less likely to use weakness ($p<.01$) and aches ($p<.01$) as signs of illness. There was a similar age related trend for headache ($p<.05$). While only these three age differences were significant, there was a consistant pattern for 4 other symptoms: older subjects were less likely to pay attention to loss of appetite, nausea/vomiting, stuffy nose, and pain. The other 9 symptoms showed absolutely no age differences.

It is not clear at this point whether these age clusters are related to increased experience with illness, an actual decrease in the occurrence of the symptoms or a reinterpretation of them as signs of aging rather than of illness. These data are being analyzed. What is clear is that the elderly appear to behave by reducing their

choices of the particular symptoms as illness warnings.

The decreased reliance on signs and symptoms as predictors of illness onset is consistent with other data obtained with patient populations. For example, in our studies of patient adaptation to cancer chemotherapy, we have found that compared to younger patients, those over 60 years of age are less distressed by the symptomatic side effects of treatment. Similarly, in a sample of 240 patients in treatment for high blood pressure, we found that compared to younger patients, those over 55 were less likely to engage in preventive health actions based on the experience of symptoms. Thus, in all of our studies, we find suggestions that older persons are less likely to engage in health actions on the basis of warning symptoms, and the finding holds whether we examine samples of people who are well, as in the present study, or samples of people who are ill, as in the studies of cancer patients and hypertensives.

Conclusion

Our findings can be summarized as follows. First, older people report engaging in a greater number of health behaviors. This is true both for specific actions which the culture accepts as effective for preventing specific diseases, and for so called 'cognitive affective' behaviors such as staying calm, etc. While these age effects are statistically reliable and consistent across 13 of the 21 actions, they are of only moderate size.

The second finding concerns the perceived effectiveness of the specific health actions. The data make clear that some actions are accepted as effective for specific diseases, the example of eating

bran to prevent colon-rectal cancer comes to mind, while others are seen to have general benefits. But while some actions are clearly seen as potent preventives, most of the behaviors are scored toward the low end of the scale and there are virtually NO signs of age differences! (Thus, while older people report engaging in more of the 21 preventive health practices, there is no indication that they are doing them because they perceive their actions to be effective, at least for these 6 diseases.)

When we compare younger to older people on the items measuring the representation of the 6 illnesses, we again find consistent age differences: older persons see themselves as more vulnerable to the illnesses, believed the illnesses would be more severe if they contracted them, etc.

We are now running a series of partial correlational analyses using a stepwise regression program to see if beliefs about the representation of illnesses, i.e. vulnerability, and severity, are responsible for the age differences in preventive health behaviors. Are older people reporting that they engage in more preventive health behaviors than younger people at the same level of perceived vulnerability and perceived severity? These analyses suggest that for colds, when controlling for vulnerability and disease severity, health actions were motivated by concern over the illness itself and age was not a causal factor. This was not the case however, for the age related diseases such as heart attack and senility, where fears about vulnerability and seriousness were not accounting for the higher frequency of reported health behaviors in older respondents.

It seems, therefore, that older persons are engaging in a greater number of preventive health actions only in part because they both feel more vulnerable and believe they would suffer more severe consequences if they were to contract one of the age specific illnesses under study. Some other age related factor appears to be responsible for their high frequency of reported health behavior. What this is is unclear. It seems unlikely to be an emotion factor as they also feel less emotionally upset or distressed at the thought of getting one of these illnesses. They also feel less able to identify warning signs or symptomatic precursors. Older people may place greater reliance, therefore, on culturally accepted norms of prevention.

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TABLE 1

REPORTED HEALTH BEHAVIORS BY AGE

HEALTH PROMOTION BEHAVIOR	AGE GROUP		
	20-39	40-59	60+
EAT BRAN OR HIGH FIBER*	3.28	3.32	3.65
AEROBIC EXERCISE	3.28	2.77	2.65
MEDICAL CHECK-UPS*	3.31	3.83	4.07
GET ENOUGH SLEEP	3.73	3.96	4.14
BREATH CLEAN AIR/PURE WATER	3.82	4.08	4.49
AVOID PHYSICAL EXERTION	2.03	2.35	2.58
EAT BALANCED DIET	3.71	3.93	4.31
AVOID HARMFUL HEALTH HABITS	3.88	4.18	4.50
AVOID SALT*	3.27	3.48	3.94

N = 396 (1 = NEVER TO 5 = ALWAYS)

ONLY THOSE WITH SIGNIFICANT AGE DIFFERENCES SHOWN (P LESS THAN .01)

*SIGNIFICANT DIFFERENCES BY SEX

FEMALES CLAIM THEY EAT MORE BRAN, MORE OFTEN HAVE MEDICAL CHECK-UPS AND MORE OFTEN AVOID SALT.

TABLE 2

REPORTED HEALTH BEHAVIORS BY AGE

COGNITIVE AFFECTIVE BEHAVIOR	AGE GROUP		
	20-39	40-59	60+
AVOID EMOTIONAL STRESS	2.84	2.86	3.25
AVOID ANGER, ANXIETY, DEPRESSION	2.88	3.03	3.63
TAKE THINGS AS THEY COME	3.26	3.37	3.61
STAY MENTALLY ALERT AND ACTIVE	4.17	4.37	4.60

N = 396 (1 = NEVER TO 5 = ALWAYS)

ONLY THOSE WITH SIGNIFICANT AGE DIFFERENCES SHOWN (P LESS THAN .01)

*SIGNIFICANT DIFFERENCES BY SEX

FEMALES CLAIM THEY EAT MORE BRAN, MORE OFTEN HAVE MEDICAL CHECK-UPS AND MORE OFTEN AVOID SALT.

TABLE 3

PERCEIVED EFFICACY OF HEALTH BEHAVIOR

	ILLNESS TYPE					
HEALTH PROMOTION	COLD	COLON	LUNG C	HEART	HIGH BP	SENILITY
EAT BRAN OR HIGH FIBER	2.58	*3.63	2.43	3.03	2.82	2.88
AEROBIC EXERCISE+	3.11	2.89	2.91	*3.77	*3.92	3.25
‡MEDICAL CHECK-UPS	2.26	*3.75	*3.64	*3.76	*3.72	3.22
GET ENOUGH SLEEP	*3.82	2.81	3.00	*3.53	3.46	3.23
BREATH CLEAN AIR/ PURE WATER	3.15	2.87	*3.84	3.36	3.00	3.22
AVOID PHYSICAL EXERTION+	2.15	2.14	1.75	2.47	1.98	2.03
‡EAT BALANCED DIET	*3.87	*3.60	3.30	*3.89	*3.85	*3.66
‡AVOID HARMFUL HEALTH HABITS+	*3.80	*3.54	*4.36	*4.37	*4.37	*3.61
AVOID SALT	2.67	3.03	2.79	*4.01	*4.32	3.28

ALL BELIEFS DIFFER SIGNIFICANTLY BY ILLNESS (P LESS THAN .001).

+ SIGNIFICANT DIFFERENCES BY AGE (P LESS THAN .05).

TABLE 4

PERCEIVED EFFICACY OF HEALTH BEHAVIOR

	ILLNESS TYPE					
COGNITIVE AFFECTIVE	COLD	COLON	LUNG C	HEART	HIGH BP	SENILITY
AVOID EMOTIONAL STRESS	3.03	2.97	2.73	*3.90	*4.03	3.06
AVOID ANGER, ANXIETY	2.97	3.02	2.81	*3.71	*3.95	3.31
TAKE THINGS AS THEY COME	2.69	2.76	2.74	*3.68	*3.64	3.08
STAY MENTALLY ALERT	3.25	2.85	2.94	*3.87	*3.71	*3.95

ALL BELIEFS DIFFER SIGNIFICANTLY BY ILLNESS (P LESS THAN .001).

+ SIGNIFICANT DIFFERENCES BY AGE (P LESS THAN .05).

Table 5

Representation of 6 Illnesses

Representation	Cold	Colon-Rectal Cancer	Lung Cancer	Heart Attack	High Blood Pressure	Senility
Vulnerability						
Likelihood	3.23	3.12	2.87	3.31	3.59	2.84
Cohort Comparison	2.83	3.04	2.80	2.82	3.06	2.51
Time of Onset	1.10	3.87	4.64	4.20	3.51	5.18
Severity						
Seriousness	2.63	4.17	4.54	4.37	4.28	3.65
Adl interrerence	2.33	3.45	3.85	3.70	2.35	3.93
Decrease Lifespan	1.21	4.45	4.69	4.52	4.29	3.07
Emotional Response						
Anger	2.07	3.51	3.71	2.86	1.94	3.34
Shame	1.28	1.86	1.48	1.45	1.33	2.90
Fear	1.19	3.79	4.24	3.79	2.53	3.40

TABLE 6

PERCEIVED EFFECTIVENESS OF HEALTH PROMOTION BEHAVIORS

REPRESENTATION	COLD	COLON-RECTAL CANCER	LUNG CANCER	HEART ATTACK	HIGH BLOOD PRESSURE	SENILITY
CONTROLLABILITY						
PREVENTABILITY	2.80	3.20	3.58	3.32	3.48	3.14
CURABILITY	2.85	3.28	3.15	3.48	2.92	2.65
EXPERIMENTATION	2.40	1.81	2.09	2.39	2.34	1.89
SELF EFFECTANCE						
ABLE TO PERFORM	3.50	3.75	4.04	3.91	4.08	3.84
APPRAISAL OF OUTCOME						
TELL WITHIN						
1 WEEK	3.07	2.18	2.08	2.67	2.72	2.57
5 YEARS	2.72	3.21	3.26	3.00	2.44	3.13

Table 7

Age Differences in Representation, Emotion and Coping Experimentation

	20-39	40-59	60+
Vulnerability			
Likelihood	2.99	3.28	3.31
Cohort Comparison	2.57	3.03	3.10
Severity	3.83	4.00	4.11
Emotional Response			
Anger	2.91	3.13	2.63
Fear	3.32	3.26	2.90
Prior Experimentation	1.90	2.24	2.49

TABLE 8

DISEASE WARNING SYMPTOMS

SIGNS & SYMPTOMS SEEN AS DISEASE	PERCENTAGES						
	ALL 6 DISEASES (396)	COLD (63)	COLON-RECTAL CANCER (63)	LUNG CANCER (68)	HEART ATTACK (71)	HIGH BLOOD PRESSURE (66)	SENILITY (65)
GENERIC							
TIREDNESS	62%	67%	46%	82%	55%	62%	60%
LACK OF ENERGY	58%	62%	52%	76%	44%	48%	66%
WEAKNESS	35%	24%	37%	56%	38%	24%	34%
DISEASE SPECIFIC							
PAIN	39%	19%	65%	54%	75%	9%	14%
LOSS OF WEIGHT	27%	3%	63%	65%	7%	6%	18%
LOSS OF APPETITE	22%	11%	35%	44%	8%	14%	25%
CONSTIPATION	14%	2%	73%	3%	1%	2%	11%
DIAHHREA	13%	10%	60%	6%	4%	2%	5%
HEADACHE	26%	60%	8%	18%	13%	52%	12%
STUFFY NOSE	16%	92%	2%	4%	1%	0%	6%
ACHES	28%	6%	22%	29%	28%	9%	22%
COUGH	31%	73%	2%	96%	14%	0%	3%
FORGETFULNESS	20%	2%	3%	3%	11%	14%	92%

TABLE 9

MEAN AGE DIFFERENCES IN USE OF SYMPTOMS AND SIGNS AS ILLNESS WARNINGS

SYMPTOM	AGE GROUPS			SIGNIFICANCE (P LESS THAN)
	20-34	40-59	60+	
WEAKNESS	.42	.31	.28	0.01
ACHES	.36	.24	.20	.004
HEADACHE	.31	.28	.20	.05